

Sound Naturopathic Clinic

20270 Front Street, Suite 103

Poulsbo, WA 98370

(360) 598-6999 (Phone)

(360) 598-2104 (Fax)

Welcome to Sound Naturopathic Clinic!

Please print and complete all (10 pages) of the following paperwork. Please allow 90 minutes for your office call and checking in and out.

Special Instructions:

- Please bring any supplements or medications you are currently taking (the actual bottles).
- If you have had any lab work done in the last year please bring the results with you.
- **We strongly suggest that you contact your insurance company prior to your visit, not all policies cover naturopathic care.** Some policies list us as a provider, but the specific plan does not cover naturopathy.
- We are a fragrance and chemical free environment. Please do not wear any perfume or use heavily scented soap prior to your visit with us.

Office Location:

Our office is located on the ground floor of the two story brown building on the corner of Bond Road and Front Street (suite103). When you are facing the building, the entrance is located on the LEFT side of the building.

Office Hours:

Monday - Thursday from 9:00 am - 6:00 pm and Friday from 9:00 am - 1:00 pm. We are closed for lunch from 1:00 pm – 2:00 pm.

If you have any questions please give us a call at (360) 598-6999. We look forward to meeting you.

In Health Light and Appreciation,

Ruth Urand ND

Dr. Sayre Limburg ND &

Staff at Sound Naturopathic Clinic

New Patient Intake.

Patient Information

Date _____ Birth Date _____ Age _____ E-Mail _____

Name _____
Last Name First Name Middle Initial

Address _____ Hm Ph# _____ Cell _____

City _____ State _____ Zip _____

Sex M F ___Single ___Married ___Long Term Partner ___Divorced ___Widowed ___Separated

Employer _____ Business Phone _____

Business Address _____ Occupation _____

How did you hear about us? _____

In case of emergency, who should we contact? _____ Phone _____

Spouse's name _____

Insurance Information

(Please complete even if your insurance may not cover you)

Person Responsible for Account _____
Last Name First Name Initial

Relationship to patient _____ Birth Date _____ Hm Ph# _____

Address _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Business Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Subscriber ID# _____ Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with _____ and assign directly to Dr. Urand all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my treatment plan is completed.

Signature _____ Date _____

Reason for Visit

Please state your present concerns in order of their significance _____

Health History

When was your last physical exam? _____ Physician's Name _____

Hospitalizations (year and reason) _____

Surgeries (year and type) _____

Serious illness or injury (year and cause) _____

Last immunization(year, type, adverse reaction)? _____

Medications

List medications you are currently taking _____

Health Habits

Alcohol Y N Tobacco Y N Caffeine Y N Soda Y N Filtered water Y N Sugar Y N

Meat Y N High fiber diet Y N Fast food Y N Dairy Y N Wheat Y N

Symptoms you experience now:

___Nausea after eating ___ Food regurgitates ___ Fullness after meals ___ No interest in food ___ Pain/burning after meals

Exercise regularly? Y N What type? _____ Duration? _____ Days per week? _____

Do you sleep well? Y N Wake rested? Y N Average hours of sleep _____

Allergies

Please list any allergies you may have to: Foods _____ Medications _____ Other _____

What happens when you have an allergic reaction? _____

Have you ever been tested for food allergies? Y N Method? _____

Elimination Assessment

Bowel Movements: _____ to _____ times per day. Do you use a stool softener, laxative or herbal laxative? Y N

Stools are: ___ Soft, well-formed ___ Large, hard ___ Large (2"x 6"L) ___ Difficult to pass ___ Medium (1"x4")

___ Diarrhea ___ Loose, not watery ___ Often float ___ Thin, long, narrow ___ Sink ___ Alt between constipation and diarrhea

Stool Odor: ___ Offensive usually ___ Occasionally ___ Little Odor Daily gas ___ Y ___ N Daily bloating ___ Y ___ N

Stool Color: ___ Brown ___ Yellow brown ___ Dark or black ___ Greasy ___ Shiny ___ Mucous ___ Blood ___ Greenish ___ Varies

Have you ever had internal bleeding? Y N When? _____

Have you ever had rectal bleeding? Y N When? _____

Have you ever had a barium enema? Y N When? _____

Have you ever been diagnosed with cancer? ___ Y ___ N

If yes, have you had Chemotherapy? ___ Present ___ Past When? _____ Radiation? ___ Present ___ Past When? _____

Family Health History	Age	Present health good/poor	Cause of death	Age at death	Type of Cancer	Diabetes	Heart disease	Other
Father								
Mother								
Brothers								
Sisters								
Children								
Pat Gr. Mother								
Pat Gr. Father								
Mat Gr. Mother								
Mat Gr. Father								
Spouse								

Review of Systems Y = a condition you have now

P = a condition you have had in the past

GENERAL

- Chills
- Depression/Nervousness
- Dizziness/Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Poor sleep habits
- Loss of weight
- Sweats
- Numbness

GASTROINTESTINAL

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive thirst
- Vomiting
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Itchy anus
- Vomiting blood
- Stomach pain

EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache/Ear discharge
- Ringing in ears
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Vision – Flashes/Halos
- Sinus problems
- Dry eyes

MEN Only

- Erection Difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other

WOMEN Only

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Vaginal discharge
- Nipple discharge
- Hot flashes
- Painful intercourse
- Other

MUSCLE/JOINT/BONE

Pain, weakness, or numbness in:

- Arms Hips
- Back Legs/Knees
- Feet Neck
- Hands Shoulders

CARDIOVASCULAR

- Chest pain
- High/Low blood pressure
- Irregular/Rapid heart beat
- Poor circulation
- Swelling of ankles
- Varicose veins

SKIN

- Bruise easily
- Hives
- Itching/Rash
- Change in moles
- Scars
- Sores that won't heal

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

- AIDS
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Cancer
- Cataracts
- Chemical Dependency

- Chicken pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Heart Disease
- Hepatitis
- Herpes
- High Cholesterol
- Gallstones

- HIV positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Mumps
- Multiple Sclerosis
- Pacemaker
- Pneumonia

- Polio
- Prostate Problem
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers
- Venereal Disease

Others: _____

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HIPPA NOTICE OF PRIVACY PRACTICES

Effective date: April 14, 2003

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of care and service you received from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you ways in which we may use and disclose health information about you. We also describe your rights to health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that indemnifies you is kept in private.
- Give you this notice of our legal duties and privacy practice with respect to health information about you.
- Follow the terms of Notices that is currently in effect.

How we may use and disclose health information about you:

- For treatment
- For payment
- For health care operation
- For appointment reminders
- As required by Law
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Workers Compensation
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiner and funeral directors
- National Security and Intelligence activities
- Protective Service for the President and others
- Security officials for Inmates

Your rights regarding Health Information about you:

- Right to inspect and copy
- Right to Amend
- Right to an Accounting of Disclosure
- Right to request restriction
- Right to request Confidential Communications
- Right to a paper copy of this Notice (full Notice is available upon request)

Change to this Notice:

We reserve the right to change this Notice. We will post a copy of the current notice in our facility with the effective date on the first page.

Complaints:

If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint.

Acknowledge:

We will request that you sign a separate form acknowledging you have received a copy of this notice. This acknowledgement will become part of your records.

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NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGMENT

We keep a record of the health care service we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about contacting the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship
(Parent, legal guardian, personal representative)

This area for staff notes (if any):

This form will be retained in your medical record.

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Informed Consent

I, _____, acknowledge that I am accepting treatment from a naturopathic doctor at Sound Naturopathic Clinic. I understand that there are intrinsic differences between the care of naturopathic doctors and medical doctors. At this time it is my decision to pursue naturopathic treatment for any condition that I have. Also, I understand that, as with any medical treatment, there is no guarantee that this treatment will offer complete resolution to any or all conditions that I may have. Furthermore, I understand that Sound Naturopathic Clinic is not to be held responsible for any adverse reaction that I may experience.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship
(Parent, legal guardian, personal representative)

Physician/Witness

Date

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Authorization to Release of Confidential Medical Records

I hereby authorize : (From previous clinic or doctor)

Facility Name: _____

Address: _____

City/State/Zip: _____

Phone # _____ Fax # _____

To release information from the health records of:

Name: _____

Date of Birth: _____

Dates of treatment: From: **2019** To: **Present**

Information to be released:

_____ **Lab results: 2019 to Present Lab Work ONLY** _____

_____ Other (specify) _____

Information is to be released to: **Ruth Urand, ND and/or**

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Purpose of disclosure: **Continuation of care**

This authorization is valid for ninety (90) days from the date signed. I understand this consent can be revoked by me at any time, unless disclosure has already occurred in compliance with this consent. I also understand that my records are protected under state and federal regulations regarding confidentiality and cannot be released or discussed without my written consent unless otherwise provided for in the regulations.

Unless specifically excluded, this authorization includes release of *specialty protected records* requiring specific written consent. This includes referral to, diagnosis of, and treatment for substance abuse, mental health conditions, and sexually transmitted diseases including HIV (CFR 42, part 2).

Certain records also require a *minor's consent* *. This applies to persons aged 13 to 18 for records pertaining to substance abuse and mental health records, or persons aged 14 to 18 for records pertaining to sexually transmitted diseases and HIV/AIDS. I specifically consent to the release and disclosure of this information.

* Minor/witness signature _____ Date: _____

Patient/guardian signature _____ Date: _____

(Fax or copy regarded as original.)

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Patient's Waiver

I _____, understand that particular charges are not billable to my health insurance, including charges for:

1. Cancellation charge (\$45.00 - \$65.00 for less than 24 **business** hours notice)
2. Colon Hydrotherapy (colonic)
3. Eustachian Tube Adjustment
4. N.A.E.T (allergy elimination treatment)
5. Nasosympatico
6. IV push – Myers' Cocktail
7. Therapeutic Injection (B-12, Neural therapy, Prolo therapy, etc)
8. Supplements
9. Hip adjustment

I understand that I am financially responsible for all charges (listed above) **at the time of service.** This does not include the payable amount by insurance, we strongly suggest that you call your insurance company prior to your office visit, not all policies cover naturopathic care.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship
(Parent, legal guardian, personal representative)

Witness/Physician

Date

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Client Fees

1. **First Office Visit** (60 minutes): \$210.00

2. **Return Office Visit** (15-30 minutes):
\$85.00 Extended Return Visit: \$140.00

These fees are minimal charges for office visits. Visits that extend past their specified time will be charged for an extended office visit. There is an additional fee for various procedures that may be performed in this office such as therapeutic injections, PAP tests, and blood draws. Supplements are also an additional charge.

3. **Phone consultation:** Brief (1-15 minutes): \$55.00
Extended (16-30 minutes): \$85.00

This fee is NOT charged if the patient is calling for clarification of on-going therapy or if the doctor has asked the patient to call. Telephone consultations are available for established patients when an office visit may not be deemed necessary or possible. Phone consultations are not covered by insurance.

4. **Cancellation Charge and No Show Fee:** There is no charge if your appointment is canceled with a minimum of 24 business hours' notice. If the office is notified with less than a 24-business hour notice, you will be charged \$45.00 - \$65.00. If we do not receive notice, the full service fees will be charged.

5. **Payment:** Payment is required at the time of service. We accept VISA, Master Card, American Express, cash and checks. There is a \$45 insufficient funds fee.

6. **Insurance:** We are an insurance provider for the following companies: Regence, Blue Cross Blue Shield, Premera, and First Choice Health Plan Network. For all other insurance companies we will provide documentation to make it possible for you to submit claims. Laboratory work originating from this office may be covered by your insurance. The laboratory handles all billing and will bill either you or your insurance company.

7. **These procedures are not covered by insurance and are separate cost:**

Colon Hydrotherapy \$125.00, Eustachian Tube Adjustment \$20.00,
N.A.E.T (allergy elimination treatment) \$60.00, Therapeutic Injection (B-12) \$30.00, Neural therapy
\$40.00, R.I.T. \$175.00, PRP \$250.00, Phone Consultations \$55.00-\$85.00.

We are committed to providing economical, quality health care.
Thank you for your patronage.